CHOICES FOR CARE
Highest Paid Provider Change Form

Participant Name: _____ Date:_____

SSN: _____

Case Manager: _____ Agency: _____

The above participant has had a change in the Choices for Care, Highest Paid Provider of services.

- **Previous** Highest Paid Provider**:** _____
- **NEW** Highest Paid Provider**:** _____
- **Effective Date:** _____

DAIL LTCCC: _____

Please make any necessary changes in patient share and send corresponding notice to the Choices for Care Participant, Provider, Medicaid Waiver Case Manager (if applicable).

(Yellow copy to DCF/ESD D.O., Original to DAIL File)